Clinical Guideline

Safe staffing Levels in Maternity Services and Operational Escalation Policy

Guidance for Salisbury NHS Foundation Trust staff

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1. Executive summary

The aim of this policy is to outline the minimum and optimum staffing levels within the Salisbury Hospital NHS Foundation Trust (SFT) maternity service and define the roles and working framework for a safe delivery of service. The policy describes how safe staffing levels are monitored and reported on and sets out to demonstrate the intention of the service to mitigate escalation where possible.
It also sets out the process of escalation for when the service becomes compromised by short staffing, increased activity, reduced capacity or is impacted on by internal or external pressures or circumstance.

This policy does not seek to describe the staffing levels and escalation policy related to the Neonatal Unit although their activity can affect the maternity services' operational capacity. This is described in a separate Neonatal escalation Policy. It is acknowledged however, that

close communication with the neonatal unit will be maintained in any maternity escalation process and is described within this document.

The Maternity Operational Escalation Levels (OPEL) Framework used both internally and externally within BSW LMNS supports clear communication and understanding throughout the escalation and de-escalation process.

OPEL Framework

The OPEL Framework has been adopted by SFT as the contemporaneous framework and language for describing the activity, capacity and safe staff resource for maternity services and consequential actions to mitigate situational challenges in order to maintain safe service provision.

Table 1. Framework definitions

Green OPEL 1	The staffing levels and skill mix are sufficient for the workload or acuity or will be within one hour across the maternity services.
Amber OPEL 2	The staffing levels and skill mix are insufficient for the workload or acuity across the maternity service. Clinical work therefore must be prioritised.
Red OPEL 3	The staffing levels and skill mix are insufficient for the workload or acuity across the maternity service. Unable to provide safe care in the service.
Black OPEL 4	The staffing levels and skills mix are insufficient for the workload or acuity across the maternity services. Unable to provide safe care across the whole service.

OPEL Framework (see Appendix 2 in checklist format)

Table 2. Opel 1 Framework

Description	**Opel 1** **The local maternity service capacity is such that organisations are able to maintain patient flow and meet anticipated demands within available resources.** **Additional support is not anticipated.**
Triggers	Business as usual.
Actions required (in hours)	Business as usual.
Out of hours	Business as usual.

Frequency of review	Business as usual.

Table 3. Opel 2 Framework

Description	**Opel 2** **The local maternity service is starting to show signs of pressure. The maternity service will be required to take focused actions to mitigate the need for further escalation.** **Enhanced coordination and communication will alert the whole system to take appropriate & timely actions to reduce the level of pressure in the system.**
Triggers	• Enough beds for delivery suite/ Labour ward to transfer to wards but not for elective activity. • High activity with high bed occupancy but beds remain available on delivery suite. • Women not assessed within 15 minutes in orange category for triage. • Moving staff to be able to give 1-1 care in established labour. • Birth rate plus activity & dependency score rating AMBER for delivery suite. • Labour ward coordinator is temporarily not supernumerary (providing direct care to antenatal/postnatal women whilst extra support for delivery suite is provided. • Delays in elective activity for > 4 hours. • Neonatal service is experiencing difficulty in meeting anticipated demand with available resources (Neonatal services escalating through Neonatal OPEL framework). Management at this level remains at Duty Manager/ Labour Ward Coordinator/ BMW Ward Lead/ Maternity Matron/ Neonatal Matron (or deputy)/ Consultant Obstetrician.
Actions required (in hours)	• 2 hourly ward rounds to ensure flow and discharge of antenatal & postnatal patients. • Labour ward coordinator. BMW ward lead and Duty manager to identify women suitable for discharge and expedite medical review where necessary Ensure all space is utilised, using waiting areas in Day Assessment Unit and postnatal area for women and babies ready for discharge • Any delays in discharges/prescribing of TTO's to be escalated to the Maternity Duty Manager. • Discussion between delivery suite coordinator/Duty manager

	of the day and consultant obstetrician to consider rescheduling all elective work both inductions and LSCS (Lower segment c-section) if clinical conditions permit • Discuss with Housekeeping services for extra cleaning staff to ensure bed and equipment is cleaned and increase through put and flow • Duty Manager and Labour ward coordinator to liaise and redeploy skilled staff according to area of need. Consider deployment specialist midwives, community midwives, whether study leave needs to be cancelled and identify if any staff can work extra/ longer shift to support safe care delivery. If Continuity of Carer model in place, should be maintained wherever possible. • Labour ward coordinator to liaise with Duty Manager and Neonatal Nurse in charge to identify and plan for any anticipated activity that necessitates neonatal cots, this may require Consultant Paediatrician and Consultant Obstetrician to discuss. • Early identification and planning where possible to ensure that women whose babies may not be accommodated on the neonatal. • Unit are transferred to other units in the daytime when staffing levels are optimal. • Request additional bank and agency staff including midwives, maternity support workers and health care workers via the Duty Manager, who will then in turn escalate via daily staffing calls. • All staff to be kept briefed of situation and actions agreed (maternity handover/safety huddles). Consider and plan additional safety huddles as required. OPEL status should be shared with the staffing and capacity team via the daily calls. Out of hours the Site team (Bleep 1312) should be informed of OPEL status.
Out of hours	Labour Ward Coordinator, Duty Manager and Consultant Obstetrician on call assess the situation and create a plan to improve the situation and call Tier 2 on call as required. They will liaise with the Trust Duty Manager to provide extra cleaning and maximise available support to manage bed clearance • Alert paediatrician on call. • If problems encountered with transporting home or to other hospitals, or women blocking beds either awaiting investigation or interim report, hospital site team to assist.

Frequency of review	Labour ward coordinator and Duty Manager to identify women suitable for discharge and expedite medical review where necessary or duty manager should: • Review OPEL Maternity Framework(MF) status which includes staffing, skill mix and bed capacity 4 hourly. The OPEL status is shared once per shift at the safety huddle and at Trust staffing and capacity meetings. • Take steps to remedy staffing levels acuity, if necessary, by redeploying staff around the service in line with activity and identify women suitable for discharge

Table 4. Opel 3 Framework

Description	**Opel 3** **The local maternity service is experiencing major pressures compromising patient flow and safety and continues to increase Further urgent actions are now required across the whole Local Maternity & Neonatal System and increased external support may be required.** **Regional Teams will be made aware of rising system pressure, providing additional support as deemed appropriate.**
Triggers	• Not enough beds on Beatrice Maternity ward (BMW) or delivery suite/ Labour ward to transfer or elective activity. • Upper limits of bed capacity on delivery suite/ Labour ward, no potential bed capacity within 2 hours. • Women not seen in red category immediately for triage. • Unable to give 1-1 care to woman/birthing person in established labour. • Birth rate plus activity & dependency score rating RED for delivery suite. • Labour ward coordinator not supernumerary. • Delays in elective activity for >24hours. • Neonatal services - very limited ability to maintain patient flow in line with ODN pathways.
Actions required (in hours)	• Ensure OPEL MF 2 actions are completed. • Duty manager update on the thrice daily sit capacity calls and inform the Divisional Director of Operations (DDO).

	• Staffing concerns or capacity issues raised. Inform divisional leadership team and active involvement of the Director/Head of midwifery/designated lead in absence of Dom/HoM. • OPEL MF 3 communication across the LMNS to alert organisation to pressure points this must also include board maternity safety champions and non-executive safety champions. • Escalation with executive level involvement and coordinated response across the ICS/LMNS (Local Maternity Neonatal System). Inform neighbouring units and obtain their status to see how they can support future diversions this will likely involve both SHIP and BSW LMNSs. • New Request for additional bank staff including midwives, nurses, maternity support workers and health care workers. • Liaise with medical wards to request support for care of any women < 20 weeks gestation. • Trust arrangements. • Consider additional nursing staff to recover women post caesarean section or following operative procedure. • Consider using prescribing pharmacist or competent nurses to complete drug rounds on wards. • Consider the option of the community midwife undertaking newborn and infant physical examination (NIPE) in the mother's own home to support rapid early discharge of mothers and babies. • Reducing and postponing community midwifery visits. For antenatal visits if a woman/birthing person requires the need for a physical examination and/or screening these visits should be maintained (A/N visits to postpone for low-risk women 16, 25, 31week appointments). Consider for postnatal visits to consider provision of care by Band 5 midwives, senior student midwives and maternity support workers. • Postpone in person visits particularly for healthy term multiparous women and their babies. • Divisional Director of Operations and Director of Midwifery to consider the potential for additional governance, data, and administrative support for maternity services, as all midwives working in those teams will be moved to support front line delivery of clinical services. • Creation, where possible, of extra high-risk labour beds – need to ensure safe staffing and availability of extra medical staff and obstetric theatre teams.

	• Local services to consider contingency plans to maintain homebirth services. • Utilisation of other staff groups including neonatal and paediatric nurses to care for transitional care babies • Continue to engage the neonatal ODNs in surge planning to ensure access to neonatal critical care is maintained and not compromised. • Ensure regular and formal contact with Maternity and Neonatal Voice. • Partnerships (MNVP), to ensure consistent communication to service users. MNVPs to share and amplify key messages to women, their families and members of the public using established communication routes. • Trust communications department to support comms across the organisation and into the community. • If all OPEL MF Status 2 actions and all the additional OPEL MF 3 actions above have been completed and the unit is still unsafe, initiate a temporary diversion for all admissions, following discussion with the on- call consultant obstetrician, Duty Manager, Director, or Head of Midwifery with agreement from the Divisional Director of Operations and the Trust duty manager and the Executive on call. • Work collaboratively with ambulance Trusts to ensure routine escalation policies are enacted when required. Inform SWAST/SCAS of Opel 3 status Staffing/capacity issues not resolved commence a divert in accordance with NHS England/Improvement Standard Operating Procedure and Reporting Process: Requesting Ambulance Diverts: https://www.england.nhs.uk/publication/operational-pressuresescalation-levels-framework/ • Report any immediate risks to the site team for escalation if appropriate. • Duty Manager, Labour Ward Coordinator, Consultant Obstetrician, Consultant Paediatrician, Consultant Anaesthetist, Maternity Matrons to maintain communication until stand down from OPEL MF 3.
Out of hours	Labour Ward Coordinator/ Duty Manager/ Tier 2 Senior Midwifery Manager on call and Consultant Obstetrician on call assess the situation and create a plan to improve the situation. • Maternity Duty manager to remain onsite whilst OPEL MF 3 status continues.

	• Maternity Duty Manager to inform the clinical site team and Trust duty manager via switchboard. • Labour Ward Coordinator/ Duty Manager/ Tier 2 Senior Midwifery Manager on call and Consultant Obstetrician on call to maintain communication until stand down from OPEL MF 3 status.
Frequency of review	Labour Ward Coordinator and Duty Manager on call to identify women suitable for discharge and expedite medical review where necessary and Duty Manager/Matron of the day should: • Review OPEL MF Status staffing, skill mix and bed capacity 2 hourly. • Bed capacity hourly review should be managed by the Duty Manager in hours and out of hours by Duty Manager on call with the Labour Ward Coordinator • Take steps to remedy staffing levels acuity, if necessary, by redeploying staff around the service in line with activity and identify women suitable for discharge.

Table 5. Opel 4 Framework

NB - depending on organisation Tier 1	**Opel 4**
Tier 2	**Pressure in the local maternity service continues to escalate leaving organisations unable to deliver comprehensive care which has the potential for patient safety to be compromised Decisive action must be taken locally to recover capacity and ensure patient safety.** **All available local escalations actions have been taken, external extensive support and intervention is required.**
Triggers	• No beds on wards • No beds on delivery suite/ Labour ward • No beds for triage • Not able to give 1-1 care in established labour • Birth rate plus activity & dependency score rating RED for delivery suite • Labour ward coordinators not supernumerary • Unable to transfer to another Trust for elective activity •Neonatal services – demand exceeds available resource.(Refer to Neonatal Escalation Policy)

	Prioritisation on a case-by-case basis is required.
Actions	• Ensure OPEL 2 & OPEL 3 actions are completed. • Director of Midwifery and Neonatal Services to inform Trust Duty Manager that divert, and closure is to be implemented. Trust Duty Manager to inform Executive on-call. • Complete checklist for suspension (Opel 4) of Maternity services (Appendix 3). • Staffing/capacity issues not resolved commence a divert in accordance with NHS England/Improvement Standard Operating Procedure and Reporting Process: Requesting Ambulance Diverts: https://www.england.nhs.uk/publication/operational-pressures-escalation-levels-framework/ • Responsible person for ICS to be notified in line with contractual arrangements and actions outlined. • Suspend all admissions to maternity unit • Suspend all community births. • In-utero transfer to a centre with a NICU is the optimal approach where preterm labour <27/40 is anticipated. All babies <27/40 (whether in - or ex-utero) must be referred for transfer to a hospital with a Level 3 NICU, if clinically appropriate. The receiving hospital should accept the referral, whenever possible, and there must be consultant to consultant discussion, which will include the obstetric consultant in the case of an in-utero transfer, to resolve any issues in relation to transfer. • In the event of extreme workforce / capacity issues, it is recognised that the availability of ambulance and midwifery staff will have significant impact on the ability to achieve this and cases will have to be decided on a case-by-case basis. This should be managed through the Maternity Duty Manager, Labour Ward Coordinator, and Consultant Obstetrician on-call. • A contingency plan must be put in place for women that may unexpectedly attend Labour Ward & triage areas without notice, to manage care safely. • Submit Datix confirming OPEL 4 status. • If there are multiple sites requiring OPEL MF 4 actions and mutual aid is being sought but is not forthcoming due to high and sustained pressures across multiple systems, which means that maternity units cannot decompress impacting on the safety of mothers and babies, the regional team to be contacted and request for out of locality/ region assistance to

	ensure a collaborative coordinated response to escalation including mutual aid where appropriate. Maternity Duty Manager, Labour Ward Coordinator, Consultant Obstetrician, Consultant Neonatologist, Director of Midwifery and Neonatal Services, Clinical Director and Divisional Director of Operations and Executive on call to maintain communication until stand down from OPEL MF 4 status.

2. Indications

2.1 Background

Appropriate staffing levels and skill mix for maternity services are essential in providing a safe maternity service. This policy is intended to outline the approved and optimum staffing levels at Salisbury Hospital NHS Foundation Trust (SFT) maternity services. It also aims to clarify how staffing is monitored and utilised when responding to activity demands of the service. Assessments of current and future workforce requirements are made locally to identify the number and experience of staff required to provide appropriate and safe cover in all care settings.

Contingency for Midwifery Staffing Shortfall

Contingency management occurs when midwifery staffing falls below optimum staffing levels or staffing resource does not meet the level of activity within the service to provide safe cover for 1:1 care in labour.

2.2 Aim/Purpose

This policy describes the safe optimum levels and appropriate skill mix of staffing required in maternity services, as recommended by the NICE Safe Midwifery staffing for Maternity Setting (2015), Royal College of Midwives (RCM) and Royal College of Obstetricians & Gynaecologists (RCOG) joint response to the Maternity Safety Strategy and Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (RCOG, 2007) which outline principles for safe staffing in place throughout all the maternity care settings.

This policy ensures that there are robust processes in place to manage the peaks of activity and any shortfalls in staffing in a safe way for women accessing the service. Where short term or long-term shortfalls in staffing are identified, the document expresses how they should be addressed.

The policy explains and makes explicit the required methods and regularity of monitoring and auditing, including the requirement for 6 monthly review of minimum staffing requirements. This policy applies to all care settings and staff working within maternity services across the following sites:

- Salisbury Hospital NHS Foundation Trust (SFT)
- Community settings including Community Midwifery Hubs, GP surgeries, and the home environment.

The purpose of this policy is to ensure:

- Appropriate staffing levels and skill mix for maternity services are essential for providing a safe maternity service. This policy is intended to outline the approved and optimum staffing levels at SFT maternity services to ensure that the required staffing resource is implemented, that staffing is responsive and workforce levels monitored.
- Assessments of current and future workforce requirements are made locally to identify the number and experience of staff required to provide appropriate and safe cover in all care settings.
- To define and make explicit the approved safer staffing levels and ratios for the maternity services.
- To describe how staff are utilised within the maternity service.
- To facilitate the monitoring of actual staffing levels and to enable comparison against the approved levels to gauge compliance with the Birthrate plus recommendations and the acuity tool.
- To outline the contingency plans in place to address short term staffing shortfalls or increase in activity.
- To outline the OPEL framework and actions taken within the stages of escalation.
- To clarify the process of communication and collaboration between maternity services at times of criticality within the LMNS (both BSW and SHIP).

2.3 Patient/client group

All women under the care of the SFT maternity services.

2.4 Exceptions/ contraindications

None.

2.5 Definitions

Table 6.

SFT	Salisbury Foundation Trust
Midwife	A person qualified to assist women during pregnancy, birth puerperium, who is registered with the Nursing and Midwifery Council (NMC).

Professional Midwifery Advocate (PMA)	Experienced practising midwives who have undergone extra training to support and guide midwives to deliver good quality and safe care developed nationally and delivered locally.
Maternity and Neonatal Duty manager	A midwife or nurse who is identified as having responsibility for the daily/ nighttime operational coordination of the maternity service.
Maternity Care Assistant (MCA)	A non-registered person with training in caring for women before, during and after birth in all care settings.
Obstetrician	A qualified medical practitioner who specialises in obstetrics who is registered with the General Medical Council (GMC) and is a member of the Royal College of Obstetricians and Gynaecologists (RCOG).
Obstetric Anaesthetist	A qualified medical practitioner who specialises in anaesthetics and has been deemed competent to work with pregnant women before, during and after labour, who is registered with the GMC.
Ward Clerk	A clerical officer who deals with administration and reception duties on a hospital ward.
Community	The wider area outside of the hospital setting in which women are treated and cared for, either in their own homes, GP surgeries or other settings.

3. Safe staffing within the maternity service

The maternity service provided by SFT is commissioned by Bath and North-East Somerset, Swindon and Wiltshire Integrated Care Boad (ICB). From September 2023 to September 2024 SFT supported approximately 2200 births.

Birthplace settings include:

- Labour ward (Acute obstetric setting)
- Beatrice Birth Centre (Midwifery led setting)

- Home

The maternity service spans both hospital and community settings ensuring that women receive care across the continuum of antenatal, intrapartum, and postnatal periods. It is also inclusive of the pre–natal diagnostic services of antenatal screening.

The maternity service is committed to multi-professional care in all aspects of the service with care being determined by the individual needs of women. The service provides training for all professional groups and support staff involved in the provision of maternity services. The majority of care in uncomplicated pregnancies is midwifery-led throughout pregnancy and birth, with referral to obstetric services where appropriate. For women accessing the alongside midwife led Beatrice Birth Centre referral to obstetric care is undertaken in the same way. Women receiving intrapartum care in the Beatrice Birth Centre are risk assessed on admission and throughout labour and will be referred into obstetric care if a risk arises. This multiprofessional approach is demonstrated in all aspects of the service with active involvement of all specialties (midwifery, obstetric, neonatal, and anaesthetic) in the organisation of the service, strategic developments, and Healthcare Governance.

The midwife led birthing environments have the inpatient matron as the professional lead and women are referred to a consultant obstetrician if the clinical need arises.

3.1 Description of the staff utilised within the Maternity Service

This section of the policy describes the staff utilised within the maternity service. Monitoring of staffing status is by a twice daily monitoring sit rep form (Appendix 2) and the acuity tool (https://acuity.birthrateplus.co.uk) accessed by user name and password.

3.1.1 Midwives, Nurses and Support Staff

It is recognised that, regardless of the place of birth or level of risk, women and their babies will be cared for by midwives. The role of the midwife, her function and scope of practice, is established in statute and cannot be delegated to anyone else.

The maternity service is committed to multi-professional care in all aspects of the service with care being determined by the individual needs of women. The majority of care in uncomplicated pregnancies is midwifery-led throughout pregnancy, birth, and the postnatal period with referral to obstetric services only where appropriate.

3.1.2 Midwives

Midwives are trained to work throughout all areas of the maternity service and to care for women throughout the continuum of pregnancy, birth, and the postnatal period.

A range of Birthplace choices are offered at SFT inclusive of home birth, an alongside midwifery led Birth centre, and the acute setting of the obstetric led labour ward. Birthplace choice is based on women's informed choice and rigorous risk assessment throughout pregnancy. The key issues relating to risk assessment for place of birth and the lead professional for labour are outlined within the Labour care and Risk Assessment at Term Guideline and gives an indication about who ought to be cared for where.

Intrapartum care is prioritised within the service and is responded to as the highest priority of care wherever the setting and in times of annual leave or sickness, cross cover for intrapartum services is found from within the entire midwifery workforce.

The midwifery workforce is managed in the main as a traditional maternity workforce model with midwives being based within the community setting or the acute hospital setting.

Midwives based within the community setting, deliver antenatal, intrapartum and postnatal care from either GP surgeries or community hubs as well as providing home visits and facilitating community births.

Midwives working within the acute hospital setting are based within the obstetric labour ward, the Beatrice Birth Centre, postnatal ward, antenatal ward, or outpatients including the maternity Day Assessment Unit (MDAU).

The hours of operating, and shift-patterns used are responsive to the needs of each element of the service and are being reviewed to ensure they meet the needs of the service but currently they are as follows:

- A scheduled care midwifery clinic, based in Maternity Day Assessment Unit (MDAU), runs Monday - Sunday, offering a Day Unit service to women between 9-5pm.
- The Birmingham Symptom-specific Obstetric Triage System (BSOTS) was developed to better assess and treat pregnant women who attend hospital with pregnancy related concerns and a BSOTS triage service for unscheduled care attendees to MDAU is utilised at SFT. The MDAU is open Monday-Sunday 0745-12.00 midnight for unscheduled care and labour triage services.
- Community antenatal and postnatal care is scheduled between Monday – Sunday 09.00 and 17:00. The service continues to make every effort to optimise access.
- Satellite obstetric clinics are available at Shaftesbury and Tidworth.
- Specialist Midwives are midwives who have developed expertise in specific areas of maternity care and are able to provide enhanced support and knowledge both to midwifery colleagues and women. Within SFT there are specialist roles for:
    - Labour ward Coordinator
    - Safeguarding
    - Infant Feeding
    - Professional Midwifery Advocate
    - Fetal Surveillance

- Bereavement
- Risk and Governance
- Practice Development
- Screening
- Mental Health
- Family Experience and Inclusion
- Pelvic Health
- Maternity Triage services - We provide an in-house 24-hour telephone advice/triage service for women in the antenatal period, in labour and postnatal period as their first point of contact. The telephone triage service is based on the BSOTS operational model.

3.1.3 Professional Midwifery Advocates

Professional Midwifery Advocates (PMAs) covering the maternity service ensure that all midwives working in the service and support:

- Monitoring and evaluating quality assurance.
- Education and development of midwives.
- Clinical supervision and revalidation.
- Streamlining personal actions for quality in midwifery work force.
- Offering hot and cold debriefing sessions.

PMAs provide a provision of support for the maternity service between 09:00 -12:30, three/four mornings a week.

3.1.4 Registered Nurses

Within the service, nurses support midwives in providing care to women and their babies in areas of care that can be overseen by a midwife but do not have to be provided by a midwife as laid out in statute. SFT maternity employ nurses to support midwives with recovery of women having elective caesarean sections on Labour ward and for postnatal care on Beatrice Ward. Cross-cover for this role is provided by midwives. As part of the short-term contingency plans, the service may consider utilising another nurse within other elements of the service; this will be entirely considered on its own merits depending on the needs of the patients and a nurse will never replace a midwife within intra-partum care or other aspects of care which a midwife may not delegate.

3.1.5 Theatres Staffing

The Theatre workforce has a dedicated team of nursing/operating department practitioners (ODP’s) and healthcare assistants employed to:

- Cover elective and emergency obstetric lists in “scrub” and “anaesthetic assistant” roles.
- Provide a full recovery service for women who have had operative interventions under general anaesthetic.

This support is provided 24 hours a day.

3.1.6 Support Staff

The maternity service utilises the invaluable resource of support roles within the hospital and within the community in the following roles:

- Maternity Care Assistants (Bands 3)
- Housekeepers (Band2)

The maternity service utilises trained maternity care assistants (MCAs) within the hospital and within the community. Maternity support workers are available 24 hours a day within the maternity service to support the normal postnatal pathway which facilitates midwifery resource to be able to provide 1:1 care in labour for birthing women. We currently have a minimum of MCAs at 10% of the midwifery workforce.

Housekeepers are utilised within the hospital service. Predominantly their role is focused on environmental cleanliness.

The maternity service also offers clinical placements for medical students, student midwives, midwifery apprentices and nurses on the Nurse-Midwife conversion course - however these are supernumerary.

3.1.7 Consultant Obstetricians

Consultant obstetricians are qualified medical practitioners who have obtained their CCT (certificate of completion of training) in obstetrics and gynaecology and who are on the Specialist register with the General Medical Council and are members of the Royal College of Obstetricians and Gynaecologists (RCOG).

As described the maternity service is committed to multi-professional care in all aspects of the service; with care being determined by the individual needs of women. The majority of care serves uncomplicated pregnancies and is midwifery-led throughout pregnancy and birth, with referral to obstetric services where appropriate. The role of the Consultant Obstetrician is to lead and develop the maternity services alongside their midwifery colleagues and in particular to influence the organisation of the service, strategic developments, and Healthcare Governance.

The consultant obstetricians are responsible for ensuring the highest standards of obstetric care is provided as appropriate along all parts of the woman’s pathway. In particular the consultant obstetrician is responsible for ensuring a high standard of care for women and their babies with complex medical or obstetric needs, and to be available for the acute, severe, and often unpredictable life-threatening emergencies. They offer clinical supervision

and education to the resident doctors throughout the service and there is always a consultant obstetrician either present or available on call for obstetric emergencies.

There is a consultant allocated to between 08.30 and 19.00 hours without any other elective clinical commitments during the day. Responsible for all unscheduled obstetric & gynaecological care.

At the weekend and during Bank Holidays, the consultant will be present from 08:30 for handover, the safety huddle and the ward round. They are also present for a second ward round – the timing of this is not set. the dedicated nonresident consultant obstetrician is available on an on-call basis and is required to be able to be present on the labour ward within 30 minutes.

SFT has 8 consultants providing non-resident consultant cover with all of them having out of hours on call commitment on a 1 in 8 basis with prospective cover.

3.1.8 Obstetric Anaesthetists

Obstetric Anaesthetists are qualified medical practitioners who specialise in anaesthetics and have been deemed competent to work with pregnant women before and during labour, and who are registered with the General Medical Council (GMC). National reports have emphasised the importance of anaesthetists as an integral part of the obstetric team and in the management of mothers who become severely ill. The maternity service has a designated obstetric anaesthetic lead with both clinical activity and administration time programmed into their job plan.

In the maternity service, Consultant Anaesthetists are present as follows:

- Ten sessions per week to support Labour Ward with both elective and emergency theatre work.

In SFT there is a dedicated Duty Anaesthetist rostered for maternity services. During core hours, this anaesthetist only covers maternity. Out of core hours, they are also part of a team which covers critical care and theatres. Their first responsibility however is to maternity, and they are immediately available when required. In addition, there is 24 - hour support from an Anaesthetic Consultant on-call (who can be present within 30 minutes) who provides cover (advice and assistance).

There are antenatal anaesthetic assessment clinics alternate Monday afternoons. These are staffed by one Anaesthetic Consultant alternate Monday afternoons.

3.1.9 Anaesthetic Assistants and obstetric theatre staff

The anaesthetists who work in maternity services are supported by dedicated trained anaesthetic assistants and obstetric theatre staff who are provided by the theatre staff within a theatre setting. The obstetric theatre is always staffed with a dedicated, competent anaesthetic assistant.

Within core hours there will be a second AP carrying a bleep in case of a second obstetric theatre being required (please see opening a second obstetric theatre SOP). In the event of theatre staffing not being sufficient to facilitate this, this must be highlighted at the morning safety huddle by the obstetric theatre scrub nurse.

Outside of core hours there are two competent anaesthetic practitioners on site. One is dedicated to providing obstetric cover and will be immediately available to do so. The other is responsible for covering main theatre cases, airway support at cardiac arrests and paediatric emergencies. They will not always be immediately available to provide additional obstetric cover.

Within core hours there is a competent obstetric theatre team available and carrying emergency bleeps. There will also be an identified second theatre team who can be called in the event of needing to open a second theatre. In the event of theatre staffing not being sufficient to facilitate this, this must be highlighted at the morning safety huddle by the obstetric theatre scrub nurse.

Outside of core hours there is a dedicated obstetric theatre team including a surgical assistant immediately available on site. If a second obstetric theatre were to be needed outside of core hours, there is a second theatre team who may not be on site and would not include a surgical assistant. They are also responsible for covering main theatre emergencies overnight and will not always be immediately available to provide additional obstetric cover.

3.1.10 Others

The care needs of women whilst pregnant can be diverse and demanding. The provision of the appropriate care to these women can only be provided when the staff caring for them have the appropriate skills. The maternity service works with a range of additional staff groups including:

- Administrative staff who are a vital and integrated part of the team.
- The neonatal workforce comprising of doctors, nurses, midwives and supporting roles.
- Specialist Allied Health Professionals including physiotherapists, sonographers, clinical pharmacists, and dieticians.
- Porters, drivers, housekeeping services, security, and other non-clinical support.

In addition, the service utilises the skills of appropriate professionals when necessary or as described within clinical guidelines used within the service.

3.2 Required staffing level

Maternity services in the NHS have seen significant change and development in the last decade which has required a review of how care is delivered to women and their families. Central to this refocus and reshaping of maternity care provision is the overarching vision for safer and more personalised care, as illustrated within the policy publication ‘Better Births’ (2016):

"…. for all staff to be supported to deliver care which is women-centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries."

This has been re-enforced by the first and final Ockenden report (2021,2022) and included within the ten safety standards for CNST.

Appropriate staffing levels and skill mix across the multiprofessional team are therefore essential in providing a safe and sustainable maternity service, whilst ensuring that women and their families receive joined-up care appropriate to their needs and wishes. This is aligned to the expectation outlined by the National Quality Board (2016) which supports NHS providers to deliver the right staff, with the right skills, in the right place at the right time. Based on national health agenda and recommendations, this section outlines the approved staffing levels within the maternity services on a local level.

3.2.1 Midwives, Nurses, and Support Staff

Staffing levels for the maternity services are determined in accordance with Birthrate Plus (NICE 2015 guidance) and Safer Childbirth (RCOG, 2007). The service is particularly responsive to 'Safe, sustainable, and productive staffing: An improvement resource for maternity services (National Quality Board, 2018) & 'NICE guideline NG4 - Safe Midwifery Staffing for Maternity Settings' (NICE 2015).

3.2.2 Maternity Services Staffing

NICE guidance recommends the use of Birthrate Plus to establish midwifery staffing numbers. Locally the maternity service has been assessed by Birthrate Plus in 2024 which supports the requirement for a higher level of enhanced care which is based on the complexity of health needs for women locally. We are currently funded for 107.27 WTE midwives which is based on annual 2200 births (2021/2022) providing a ratio of 1:24.

Meeting these requirements is influenced directly by the number of different care providers required to keep staffing safe and sustainable. SFT are committed to ensuring an appropriate workforce with the necessary skills providing good quality, compassionate care in the right place at the right time with the right skills in line with Getting it Right First Time (GIRFT).

Whilst we aspire to meet the national recommendation for safe and sustainable staffing levels within the maternity service, we also acknowledge the value of expanding skill mix to ensure efficient use of staff, through Birthrate Plus and Nice guideline NG4 (2015). It is recommended that some 'midwifery' time can be reallocated to appropriately trained and graded support staff within the postnatal and community services to facilitate the midwifery workforce in providing 1:1 care in labour.

Within this workforce it should be acknowledged that the number of maternity care assistants (MCAs) acting within a supportive framework to the midwifery role is crucial in providing a safe service.

3.3 Optimal and Minimum Staffing Levels

Midwifery clinical leadership is provided by matrons in each clinical area and within the community.

Matron for inpatient care -Intrapartum, antenatal and postnatal services

Matron for outpatient services –
community, antenatal clinic
services, maternity day assessment
unit (MDAU) and telephone triage

Tables 7 - 9 demonstrate optimal and minimum midwifery and support staffing levels within all care settings.

3.3.1 Birth Environments

Intrapartum care is prioritised within the service and is responded to as the highest priority of care wherever the setting and in times of annual leave or sickness cross cover for intrapartum services is found from within the whole team.

3.3.2 Obstetric Labour Ward

In order to ensure safety, there will be a Specialist midwife - Labour ward Coordinator on every shift who is responsible for oversight and coordination of the Labour Ward. Staffing on Labour Ward will be as follows:

Table 7.

11 birth rooms **0 bed recovery**	**Early**	**Late**	**Night**	**Early**	**Late**	**Night**
	Optimum staffing			**Minimum staffing**		
Labour Ward Coordinator	1	1	1	1	1	1
Midwives	5	5	5	4	4	4
Nurse	0	0	0	1	1	1
Maternity Support Worker	1	1	1	1	1	1
Housekeeper	1			1		

Deployed across all environments							

3.3.4 Beatrice (antenatal and postnatal) ward

Table 8.

15 Postnatal beds & antenatal beds	**Early**	**Late**	**Night**		**Early**	**Late**	**Night**
	Optimum staffing				**Minimum staffing**		
Senior Midwifery Practitioner & Senior Shift Leader	0	0	0		0	0	0
Midwives	2	2	2		1	1	1
Maternity Support Worker	1	1	1		1	1	1
Housekeeper Deployed across all environments							

3.3.6 Maternity Day Assessment Unit

Table 9.

MDAU 4 Beds		**Early**	**Late**	**Night (Twilight)**		**Early**	**Late**	**Night (Twilight)**
		Optimum staffing				**Minimum staffing**		
Band 7 shift leader		0	0	0		0	0	0

Midwives		1 + 1 scheduled care	1 + 1 scheduled care	1	1	1	0
Maternity Support Worker		1	1	0	1	1	0

3.3.7 Maternity Triage services

We provide an in-house 24-hour telephone advice/triage service for women in the antenatal period, in labour and postnatal period as their first point of contact. The telephone triage service is based on the BSOTS operational model and is staffed by one midwife Monday to Sunday 08:30 - 17:30.

3.3.8 Consultant Obstetricians

As of September 2024, the consultant presence is as follows:

Table 10.

	Mon	**Tues**	**Wed**	**Thur**	**Fri**	**Sat**	**Sun**	**Total**
Consultant Obstetrician Present	08.30 – 19.00	08.30 – 19.00	08.30 – 19.00	08.30 – 19.00	08.30 – 19.00	08.30 11.30– and 1 hour PM/evening	08.30-10.30 and 1 hour PM/evening	

Table 11.

Hours (Prospectively covered)	10.5	10.5	10.5	10.5	10.5	4	4	60.5
Non-resident On call Cover	19:00 - 08:30	19:00 - 08:30	19:00 – 08:30	19:00 – 08:30	19:00 – 08:30	Outside of hours stated above	Outside of hours stated above	
ROC	0	0	0	0	0	0	0	0
Hours covered	24 hours 1 in 8	24 hours 1 in 8	24 hours 1 in 8	24 hours 1 in 8	24 hours 1 in 8	24 hours 1 in 8	24 hours 1 in 8	24 hours 1 in 8

3.3.9 Anaesthetists

The role of the anaesthetist is an integral part of the maternity services team, and the staffing levels need to recognise that emergencies happen frequently and often with rapidity, with a requirement to respond quickly in order to save mothers' or babies' lives.

In line with the guidance included within Safer Childbirth (RCOG 2007), the maternity service requires the following minimum standards of anaesthetic cover:

- Ten consultant programmed activities or sessions per week, to allow full 'Working hours' consultant cover. There are occasional sessions where an ST5 or above registrar or specialty doctor, may be asked to cover delivery suite during core hours to cover leave. There is always a consultant anaesthetist available to assist/advise if required (Consultant carrying the star bleep 1713).
- Additional clinical time for antenatal anaesthetic review.
- A named lead obstetric anaesthetist with programmed activities as required.

This is provided at SFT as follows:

Table 12.

	Mon	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**
Consultant or Associate Specialist Anaesthetist	08:00 - 18:00	08:00 - 18:00	08:00 - 18:00	08:00 - 18:00	08:00 - 18:00	Covered by Duty Anaesthetist	Covered by Duty Anaesthetist

Present (prospectively covered) Competent anaesthetic present (prospectively covered)	08:00 - 13:00	08:00 - 13:00	08:00 - 13:00	08:00 - 13:00	08:00 - 13:00		
Duty Anaesthetist (specialist trainee)	18:00 - 08:30	18:00 08:30	18:00 - 08:30	18:00 - 08:30	18:00 - 08:30	24 hours	24 hours
On call Consultant Anaesthetist available	18:00 - 20:00 Resident 20:00 - 08:00 On-call Non-resident	18:00 - 20:00 Resident 20:00 - 08:00 On-call Non-resident	18:00 - 20:00 Resident 20:00 - 08:00 On-call Non-resident	18:00 - 20:00 Resident 20:00 - 08:00 On-call Non-resident	18:00 - 20:00 Resident 20:00 - 08:00 On-call Non-resident	08:00 - 18:00 Resident 18:00 - 08:00 On-call Non-resident	08:00 - 18:00 Resident 18:00 - 08:00 On-call Non-resident

SFT have monthly anaesthetic clinics on alternate Monday afternoons. There is also a named lead anaesthetist for obstetrics.

3.3.10 Anaesthetic Assistants and Obstetric Theatre Staff

It is essential that trained anaesthetic assistants are available. The follow represents minimum standards for this requirement:

Table 13.

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Emergency Theatre (24 hours)	1 per shift	1 per shift	1 per shift	1 per shift	1 per shift	1 per shift	1 per shift
Formal 2nd theatre	08:00 - 18:00	08:00 - 18:00	08:00 - 18:00	08:00 - 18:00	08:00 - 18:00	No formal provision	No formal provision

3.3.11 Other Staff Groups

Staffing levels for other staffing groups including administrative staff, the neonatal unit and clinical and nonclinical support are not within the scope of this document.

3.4 Staff Duties

The responsibilities of some groups of staff working on the labour ward are clearly defined within national guidance.

3.4.1 Specialist Midwife-Labour Ward Coordinator

As a minimum standard there is a designated specialist midwife identified as a Labour ward coordinator who provides clinical leadership on each shift on the labour ward and should remain supernumerary status to coordinate and have oversight and situational awareness of the evolving clinical activity within the obstetric labour ward. This person is clearly identified via the rostering system to ensure that this role is a consistent presence. The coordinator's name is written on the Labour Ward board on a daily basis to ensure that all staff are aware of who this person is.

The Labour Ward Coordinator role includes:

- Coordination of the multidisciplinary team on shift and provision of leadership, advice, supervision of midwifery and care staff for labouring women across the service.
- Labour Ward Coordinator shifts are rostered in a way that allows the labour ward coordinator to have supernumerary status (defined as having no case load of their own during that shift).
- Mentoring, supervision and advice for midwives and others.
- Liaison with and support for the obstetric and neonatal teams.
- Escalation of suboptimal staffing, increased capacity and other significant issues to the professional midwifery advocate, duty manager on call, trust-wide site coordinator as appropriate as indicated by the OPEL framework.

If a Labour Ward Coordinator is not available at the start of the shift the actions will be as follows:

- Outgoing Labour Ward Coordinator to inform Duty Manager.
- Outgoing Labour Ward Coordinator to continue in the interim until a replacement coordinator is sourced.
- Duty manager to explore the availability of Labour Ward Coordinators in work but fulfilling other roles (management day, duty manager role, specialist midwife role, inpatient matron) or those currently not at work but available to work.

3.4.2 Consultant Obstetricians

Whilst maternity services provide a number of hours of prospective consultant presence on the labour ward in line with the recommendations of Safer Childbirth (RCOG 2007), it is also

expected that the consultant will attend the labour ward in person (if they are not already present) when it is deemed necessary. SFT have a standard operating process (SoP) based on the RCOG paper 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'

As the most experienced medicial clinician, consultants are now often needed to be physically present, including out of hours, to support the care of more complex women or during high levels of activity. The two tables below describe the clinical scenarios and situations when consultants should be informed and when they should attend in person.

The two tables below describe the clinical scenarios and situations when consultants should be informed and when they should attend in person.

3.4.3 Situations in which the consultant MUST ATTEND

- In the event of high levels of activity e.g., a second theatre being opened, unit closure due to high levels of activity requiring additional consultant obstetrician input.
- Any return to theatre for obstetrics or gynaecology.
- Team debrief requested (unless being led by another senior personnel).
- If requested to do so e.g. the Obstetric Middle Grade doctor or the Labour Ward Coordinator request additional support or guidance.
- Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary.
- Caesarean birth for major placenta praevia / abnormally invasive placenta.
- Caesarean birth for women with a BMI > 50.
- Caesarean birth < 28/40.
- Premature twin delivery (< 30/40).
- 4th degree perineal tear repair.
- Unexpected intrapartum stillbirth.
- Eclampsia
- Maternal collapse e.g., septic shock, massive abruption.
- Major Obstetric Haemorrhage that is ongoing and uncontrolled > 1500mls where the Massive Obstetric Haemorrhage protocol has been instigated.
- For a second scan in an unexpected intrauterine death, where no other trained

3.4.4 Situations in which the **consultant must attend** unless the most senior doctor present is competent to perform these procedures under distant supervision.

In these situations, the senior doctor and the consultant should decide in advance if the consultant should be INFORMED prior to the senior doctor

- Any patients in obstetrics with an EBL > 1.5 litres and ongoing bleeding (including women in early pregnancy).
- Trial of instrumental birth
- Vaginal twin birth
- Caesarean birth at full dilatation
- Caesarean birth for women with a BMI > 40
- Caesarean birth for transverse lie
- Caesarean birth at < 32/40
- Vaginal breech birth
- 3rd degree perineal tear repair

undertaking the procedure.

Situations in which the **consultant should be informed:**

- Trial of Instrumental delivery going to theatre
- Emergency Caesarean section going to theatre
- Major Obstetric haemorrhage >1500ml
- Any severe pre-eclamptic / eclamptic patient on protocol and having IV anti-hypertensives.
- Unexpected Intra-uterine fetal death (antenatal or intrapartum).
- Any patient severely unwell or collapsed for any cause eg: Severe Sepsis, Uterine rupture, anaphylaxis, cardiac arrest.
- Any time the LW co-ordinator, Middle grade doctor, or ANY member of staff have significant concerns and need guidance.

3.4.5 Obstetric Anaesthetist

Delivery of anaesthesia and analgesia is the mainstay of obstetric anaesthetic practice, but it can only be done safely if the service is coordinated and organised. This responsibility falls to the clinical lead for anaesthetics and theatre manager.

For the maternity services there is a designated lead obstetric anaesthetist. This person's role includes:

- Leadership and development of the maternity services alongside other senior obstetric and midwifery colleagues.
- Responsibility for ensuring that there is a 'duty anaesthetist' immediately available for the obstetric unit 24 hours a day.

- Ensuring that the duty anaesthetist has access to prompt advice and assistance from a designated consultant anaesthetist whenever required.

The “duty anaesthetist” is assigned by the anaesthetic department, and the roster is published with the designation for maternity service; this member of staff is responsible for:

- Ensuring the safe anaesthesia and analgesia of women within the maternity services who are referred by obstetric doctors and midwives.
- Reviewing post-partum and post-operative women to ensure their ongoing safe management.
- Responding to emergencies as they occur throughout the service.
- Escalating the demand for additional anaesthetic input to the anaesthetic consultant in charge and the On-call Consultant Anaesthetist as required. An obstetric anaesthetic escalation SOP is available.

3.5 Multidisciplinary Ward Rounds on the Labour Ward

To safeguard safety and appropriate escalation of concerns or issues on the Labour Ward the maternity service ensures that there is a consultant led ward round twice daily (over 24 hours) and 7 days per week. This ensures that the Labour ward staff are working together to provide multidisciplinary team working. Where there is no consultant presence then a Datix should be completed. A review of the incident should take place and actions implemented to ensure improvement. A monthly audit is undertaken as part of safety standards for CNST.

3.6 Oversight of Midwifery Staffing Levels

The Director of Midwifery and Neonatal services, Head of Midwifery and Neonatal services and the Divisional Director of Operations are jointly accountable for overseeing the review of midwifery staffing, and for ensuring actions are taken forward required from the review. The allocated workforce leads draw together data recorded on the live establishment trackers and from supporting information from the maternity service acuity tool to summarise compliance with all standards within this document, both local and national.

Each month the maternity service reviews and reports the midwifery staffing levels within the Perinatal Quality slides which are shared at Trust Board and with the LMNS and ICB. In addition the bi-annual safer staffing paper and the quarterly Quality and Safety reports includes a review of all vacancy rates, absence (sickness, study days and annual leave), as well as fill rate for bank and agency shifts. Red flags related to staffing are also reviewed and reported having been cross checked using the Acuity tool.

Every six months a safer staffing paper is presented to Trust Board via the Clinical Governance committee and presented at Trust Board by the Director of Midwifery in addition to ensure the board has clear oversight of midwifery staffing

The Trust Board will be responsible for determining whether short-term contingency, long-term contingency or business planning is required. This report is required to comply with part of the clinical negligence scheme for Trusts, **Safety action 5**: *Can you demonstrate an*

effective system of midwifery workforce planning to the required standard. The report provides an overview of staffing for the previous 6 months alongside the recruitment trajectory to reduce vacancies. The review will consider the current numbers of births, the recommendations of national guidance, i.e., NICE Maternity Staffing 2015 and Safer Childbirth (RCOG 2007) and any local expectations for safe staffing. The Trusts funded staffing establishment position against the most recent Birthrate Plus assessment will also be evidenced. The review will reflect staffing levels specifically at the point of the review and will make recommendations regarding required actions for identified gaps. It will also indicate the number of red flags raised as a result of compromised staffing.

3.7 Operational Process for the Review of Midwifery Staffing Levels

Every four hours the acuity tool is completed by the Labour ward co-ordinator, and this provides a real-time overview of the acuity, capacity and staffing of the Labour ward. Similarly the Beatrice ward acuity tool is completed every 6 hours which provides an overview of the acuity and capacity. The escalation from this is directed to the Labour ward co-ordinator and duty manager. The Maternity and Neonatal duty manager attends the thrice daily Trust capacity calls which provides a whole service overview of acuity, capacity, and staffing. Each Matron also has oversight of individual clinical areas within their remit and communicates by exceptional escalation to the HOM/Dom as needed.

On a daily basis, the duty manager and workforce lead review any staffing shortfalls in advance and mitigate any problems as soon as possible.

The maternity service track monthly key staffing indicators to ensure safety and this is achieved through regular scrutiny of the ‘live’ staffing establishment trajectory. The vacancy rate is reported to both Maternity and Neonatal Governance, Divisional Governance and Trust via the Perinatal Quality slide pack. Maternity safe staffing indicators are under continuous review and therefore escalation or identification of need may happen at any point during the year and actions that are short, medium, or long-term may be taken at any point when deemed necessary.

It is important to recognise that the production of the monthly and six-monthly review is supplementary to the continuous vigilance regarding staffing and safety which is required. The maternity services contribution to the Trust board meeting monthly via the Perinatal Quality slides has the following functions:

- Assuring the Division that there is a review into all elements of Midwifery staffing.
- Ensuring that short, medium, and long-term actions are considered, and escalation of issues occurs as necessary.
- Assurance to the Board that Midwifery staffing is monitored and reviewed frequently to demonstrate safe staffing.

3.8 Contingency Planning

A key element of quality assurance is the safety of the maternity services at times of peak pressure. The maternity service plans robustly for peaks in activity and undertakes detailed

risk assessments to ensure safety for all mothers and babies. The number of times that the service externally diverts activity due to a peak in activity and capacity is minimal. However, staffing is reviewed daily to respond to peaks in activity and to prioritise care of labouring women. This can also mean that women's choice can be limited in terms of place of birth due to capacity and or staffing resource.

3.8.1 Short Term Contingency

The maternity services prioritise care in the following manner:

- One to one care in labour (in all settings)
- Acute antenatal and postnatal care
- Day assessment unit
- Routine antenatal and postnatal community care

As a routine, rigorous oversight of staff rosters occurs prior to the rosters being published and there is a daily review to mitigate for when staff sickness occurs. Wherever possible SFT midwifery bank staff are employed to cover identified gaps but if required specialist and office-based midwifery staff are required to work clinically in exceptional circumstances. Midwives can flexibly work across all areas of the midwifery pathway and when required respond to clinical priorities within the service. SFT also ensure the following:

- Robust on call availability consisting of the first on call being a senior midwife/matron in the 'Duty Manager' role and the second on call is a senior maternity manager on call who in extreme incidents and pressures should be escalated to.
- The community midwife 'on call' at night is also available to support the short-term contingency plans.
- Redeployment of staff throughout the entire service to support the priorities of care, and in particular intrapartum care.
- Consideration of reduction or diversion of activity or redirection of women, including curtailing activity in one or more birthplace location, where all other options have been exhausted.

3.8.2 Longer term contingency plans

3.8.2.a Maternity Dashboard

A national recommendation was that all NHS providers must ensure that they have robust systems in place for the monitoring of quality and performance of the maternity services. The Maternity Dashboard is a tool that has been collaboratively developed to support this recommendation.

The intention of the dashboard is that there should be a clear, robust mechanism for ensuring quality and performance is monitored monthly with key and agreed indicators for safety and standards. The following groups review the dashboard:

- Maternity and Neonatal Governance
- Divisional Performance Review (as a watch metric)

All these groups are in a position to monitor a range of key quality indicators and have the authority to identify the need for longer-term contingency plans with regards to safe midwifery staffing.

Where plans have been put in place, they will be reported at Divisional Governance who may request that further action is taken. Final plans will be escalated to Trust Board for information or approval via escalation through the Clinical Governance committee (CGC).

3.9 Long Term Staff Planning

As each scenario requiring a longer-term contingency plan may have different characteristics and therefore required solutions, the key themes are presented here.

- Recruitment and retention play a vital role in maintaining a safe service. The maternity service has a multifaceted strategy for recruitment:
    - Investing in SFT trained student midwives as newly qualified staff
    - Taking the lead for recruitment to international midwives
    - A planned over recruitment of midwifery staff to mitigate the acknowledged turn over in maternity
    - Integrating RNs within the workforce to support the role of the midwife
    - Offering midwifery apprenticeships for both MCAs and RNs.

- Retention of staff is imperative and creating a working environment where staff choose to stay is an important feature for safe working practice. SFT actively engage in:
    - Developing staff
    - Creating opportunities for career progression
    - Engaging and working with staff to create a positive culture
    - Annual staff surveys to hear what works well and what SFT can do better

- Where there is an absence in a senior leadership role, it is usual to identify a replacement in an “acting up” or “cross-covering” capacity; this applies to all relevant clinical leadership roles. The process for agreeing this will usually be from within the maternity services and may involve either a direct appointment or a more formalised selection process.
- In scenarios of reduced numbers of effective workforce in Midwives, Nurses, and Support Staff an assessment will be made by the relevant Duty manager and matron with support from the Director of Midwifery and the Head of Midwifery along with the Divisional Director of Operations, as to whether a longer-term contingency plan is required. Such scenarios include restricted practice, long-term sickness, suspension, maternity leave, or other long-term leave. Options for addressing this shortfall include:
    - Recruitment of fixed term posts.
    - Recruitment to permanent posts (where turnover is such that this can be facilitated without compromising the existing post-holder).
    - Recruitment of more Registered Nurses to mitigate a Midwifery shortfall.

Where approval is required outside of the senior maternity team, for example with recruitment, the Divisional Performance Review Group will be asked to approve the contingency plan.

3.10 Consultant Obstetricians

The Gynaecology Clinical lead is responsible for ensuring that there is a consultant covering both the “present” and the “on call” sessions. Where there is a short-term shortfall, the cover for this is facilitated by the consultant team. Actions which may be needed to facilitate a short-term shortfall (e.g., sickness) may include:

- Cancelling of any direct clinical care (DDC) sessions e.g. Gynae clinics
- Cancelling of other commitments (CD or SPA).
- Cancellation of annual leave.
- Locum shifts from a suitable individual.

The process for achieving this is that the Gynaecology Clinical lead (or designated representative) will agree a plan with the consultant team and the rota will be updated to reflect this (while respecting terms and conditions of the service).

3.11 Anaesthetists

The Surgical division is responsible for ensuring that there is a senior anaesthetist covering both the “present” and the “on call” sessions. Where there is a short-term shortfall, the cover for this is facilitated by the consultant team. Actions which may be needed to facilitate a short-term shortfall (e.g., sickness) may include:

- Cancelling of other commitments (non clinical time).
- Cancellation of annual leave.
- Locum shifts from a suitable individual.

The process for achieving this is that the clinical lead (or designated representative) will agree a plan with the consultant team and the rota will be updated to reflect this.

3.11.1. Anaesthetic Assistants

The Theatre management team are responsible for ensuring that all obstetric theatres have an appropriately trained competent member of staff. Where there is a short-term shortfall, the cover for this is facilitated by the existing theatre team with the potential to draw on the wider team if essential. Actions which may be needed to facilitate a short-term shortfall (e.g., sickness) may include:

- Cancelling of other commitments (elective activity, or non-clinical duties)
- Cancellation of annual leave.
- Agency or overtime shifts from a suitable individual.
- Out of Hours there is access to support from anaesthetic assistants

The process for achieving this is that the Matron (or designated representative) will agree a plan with the theatres team and the roster will be updated to reflect this.

3.12 Escalation of Staffing Concerns

During times of peak activity/minimal capacity for staffing or environment there is a defined pathway of communication to ensure that there will be clear and safe arrangements for the care of mothers and babies. If the labour ward becomes overwhelmed due to activity and consider they have reached OPEL 3. This will be evidenced on the acuity tool. The actions as outlined in the executive summary will be taken before escalation to OPEL 4. Diversion of activity from SFT maternity services will only be considered as an absolute last resort when all other potential solutions are exhausted.

Any staffing concerns are escalated using the OPEL framework and will be reported as an incident as outlined in the DATIX Incident Reporting Policy.

3.12.1 Escalation from OPEL 1 communication process

Day time hours

08:00-17:00 hours escalation process summary

1. Labour Ward Coordinator (LWC) will inform the Duty Manager that additional staffing is required or that there are capacity concerns. The Duty Manager will attempt to resolve the issues.
2. The Duty Manager will determine where local staffing can be redeployed from. The following areas should be considered: specialist midwife roles, community midwifery teams, matrons, and other midwifery managers. Text messages will be sent to midwives and maternity care assistants (MCA) offering additional hours to be paid as bank payments.
3. If issues are not able to be resolved locally the Duty Manager will escalate to the inpatient or outpatient services Matron who will discuss the issues and ask for the Birth Rate Plus Acuity tool to be completed and consider the OPEL status.
4. The Matron will discuss the current activity status with Head of Midwifery and decide the next step to take.
5. If activity levels are such that local support cannot resolve the issue, and escalation from OPEL 3 to OPEL 4 is required, the Director of Midwifery and Neonatal Services, and in her absence the Head of Midwifery and Neonatal services, should be on site and the actions within the OPEL framework should be instigated.
6. Documentation for closure at OPEL 4 (Appendix 4,5,6,7).
7. A DATIX should be submitted.
8. All of the above will be reported by the Duty Manager to the Trust staffing and capacity meetings at 09:00hrs, 09:15hrs, 12:00hrs, 15:00hrs (and 17:00hrs if required) to ensure Trust oversight.

Outside Daytime hours and weekends and public holidays

17:00-08:00 hours escalation process summary

1. If the activity overnight increases and additional staffing is required to maintain a safe service, the LWC's first action will be to contact the on-call community midwife to attend the acute site.
2. If following the attendance of the community on call midwives there is still a staffing deficit, or activity rises further, the LWC should complete the Birth rate plus acuity tool prior to contacting the overnight duty manager.
3. At this point the Duty Manager will discuss the activity and review the completed acuity tool with the LWC and make an assessment.
4. If OPEL 3 has been reached the Senior Manager (Matron/HOM/DOM – Tier 2) on call should be contacted to discuss the current actions.
5. At 08:00 when the Duty Manager finishes they should update the Inpatient and Outpatient Services Matron with a brief synopsis of calls. If there have been any significant incidents, then the Duty Manager should inform the on-call senior manager (Matron/HOM/DOM- Tier 2) by telephone.
6. If activity levels are such that escalation from OPEL 3 to OPEL 4 is required, the senior on- call manager should be on site and the actions within the OPEL framework should be instigated.
7. Documentation for closure at OPEL 4 (Appendix 4,5,6,7).
8. A DATIX should be submitted.

The Birth Rate Plus acuity toolkit has 3 levels of acuity compliance:

Table 14.

COLOUR	SHORTFALL OF MIDWIVES
GREEN	Meets acuity compliance
AMBER	Up to 2 midwives short
RED	2 or more midwives short

The LWC will need to provide this information, along with actions undertaken already to the Duty Manager if at OPEL 3 and include this in the Datix logged.

There are acknowledged factors that will trigger the escalation process:

- Insufficient midwives or obstetric doctors.
- Inappropriate experience/skill mix to provide high dependency care.
- Acute shortage or no available beds.

- Limited or no Neonatal unit capacity or clinical support.
- Infection in clinical areas – advised by a microbiologist.
- In the event of a major epidemic, incident, or power failure.

Should a major incident occur not specifically related to maternity but closure to support incident is required, then the Major Incident Plan should be implemented.

3.13 Roles and responsibilities

This policy applies to all clinical staff employed or contracted by SFT who provide care to women. Staff have a responsibility to ensure that they are aware of this policy and its contents. They should clearly document their rationale if they have not complied with the recommendations detailed in this policy. It is the responsibility of department managers, consultants, team leaders and education leaders to ensure staff are aware of this policy.

It is the responsibility of staff to abide by the policy and service managers to ensure that the policy is adhered to.

- Divisional Clinical Director (DCD) has overall clinical responsibility for all services in the Division.
- Divisional Director of Operations (DDO) has overall responsibility for the operational and strategic leadership of all services in the Division.
- Director of Midwifery and Neonatal services (DoM) is responsible for all non-medical clinical care, including nursing and midwifery and strategic leadership for Maternity and Neonatal Services.
- Head of Midwifery and Neonatal services (HoM) is responsible for site specific clinical activity and midwifery, nursing, and support staffing at all levels, with a focus on operational responsibility, and to deputise for the DoM in her absence.
- Operational Manager is responsible for service operational targets and activity
- Divisional Finance Manager is responsible for supporting the maternity service in all aspects of finance and budgeting
- Divisional HR Business Partner is responsible for supporting the maternity service in all aspects of human resources and workforce planning.
- Midwifery Matrons are responsible for clinical leadership and management of staff and the designated areas within the remit of their professional role.
- Professional Midwifery Advocate (PMA) is responsible for providing restorative supervision to midwifery staff and maternity support workers ensuring ongoing clinical support and advocating for quality and education.
- Labour Ward Coordinator (LWC) is responsible for clinical leadership and management on each shift on the labour ward.

4. Information for Women

5. Audit

The policy will be displayed on the maternity trust website and available for aligned clinical services within the Trust. The matrons will be expected to cascade to all relevant staff groups. All medical, nursing and midwifery staff caring for women and new-borns should have support and training in implementing the contents of the policy. In addition, the policy will be included in local induction programmes for all new staff members.

5.1 Audit Indicators and design

Key aspects of the procedural document that will be monitored:

Table 15.

What aspects of compliance with the document will be monitored	What will be reviewed to evidence this	How and how often will this be done	Detail sample size (If applicable)	Who will coordinate and report findings (1)	Which group or report will receive findings
That information regarding staffing is contained within the Maternity Services staffing report.	The Maternity Services Staffing report.	Monthly and six monthly.	N/A	Director of Midwifery	Maternity Governance Meeting
Confirmation of a Consultant led labour ward round twice daily (over 24 hours) and 7 days per week.	Audit of the consultant rota demonstrating 24/7 named labour ward consultant. This demonstrates that the named individual is not doing	Bi-annually	N/A	Obstetric Lead	Maternity Governance Meeting

	another session such as clinic concurrently Audit of Datix's reporting lack of consultant presence on the LW.				
Confirmation that the maternity service has escalated appropriately using the OPEL framework.	Audit of the number of times the service has progressed to OPEL 3 and OPEL 4 and rationale.	Monthly	N/A	Head of Midwifery	Maternity Safety Champions

Where monitoring identifies deficiencies, actions plans will be developed to address them.

5.3 Related Trust policies

The following list is a guide only and is not exhaustive:

- Escalation Policy – Neonatal Unit
- Conflict of Clinical Opinion guideline
- Maternity and Neonatal Governance Framework
- Duty Manager SOP - Maternity
- Maternity Safety Champions role SOP
- Structure of the Labour Ward Day and Handover of Care SOP
- Attendance Management Policy and Procedure
- Maternal Collapse guideline
- Postpartum Haemorrhage guideline
- Flexible Working Policy
- Policy for the Use of Bank and Agency Workers
- Managing Attendance Policy
- e-Rostering policy
- Professional Registration Policy
- Trust Major Incident Plan

- Responsibilities of the on-call consultant SOP (in the department of Obstetrics and Gynaecology).

5.4 Implementation

The policy will be displayed on the maternity trust website and available for aligned clinical services within the Trust. The matrons will be expected to cascade to all relevant staff groups. All medical, nursing and midwifery staff caring for women and newborns should have support and training in implementing the contents of the policy. In addition, the policy will be included in local induction programmes for all new staff members.

5.5 Contributors

Table 16.

Contributor Job Title	**Contributor Name**
Director of Midwifery and Neonatal Services	Vicki Marston
Divisional Director of Operations	Hannah Boyd
Consultant Obstetrician and Gynaecologist	Charlotte Atkinson
Consultant Obstetrician and Gynaecologist	Greg Pearson
Consultant Obstetrician and Gynaecologist	Annie Hawkins
Consultant Anaesthetist	Julia Bowditch
Consultant Anaesthetist	Juliet Barker
Inpatient Services Matron	Rebecca Roberts
Quality and Safety Matron	Danielle Freemantle
Consultant Obstetrician and Gynaecologist	Yazmin Faiza
Midwife	Emma Twine
Antenatal Clinic Lead Midwife/Psychological wellbeing Lead Midwife	Nicola Boardman
Audit and Guidelines Lead Midwife	Faye Ballard
Beatrice Maternity ward Lead Midwife	Helen Cross

6. Evidence Base

6.1 References

NICE Safe Midwifery Staffing for Maternity Settings - https://www.nice.org.uk/guidance/ng4

Safe, sustainable, and productive staffing in maternity services -

https://improvement.nhs.uk/documents/1353/Safe_Staffing_Maternity_final_2.pdf

Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour

https://www.rcog.org.uk/en/guidelines-research-services/guidelines/safer-childbirthminimum-standards-forthe-organisation-and-delivery-of-care-in-labour/

Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology (RCOG) 2022 Roles and responsibilities of the consultant workforce report (May 2022 update)

South West Maternity Escalation Policy & Operational Pressures Escalation Levels Framework (NHSE & I)

7. Appendices

7.1 Appendix 1 – Datix reporting red flags

RED FLAGS – Datix reporting

Ensure that any of the following incidents are reported on Datix and indicated to be MATERNITY RED FLAG incidents (matron to Datix if not been done):

- Unplanned omission in patient medications.
- Delay of >60 Minutes in providing regular analgesia or >30 mins for PRN / Labour.
- Omitted or delayed recording of observations / pain score or failure to act on abnormal signs.
- Staff unable to take break.
- Delay of >2 Hrs between admission for IOL and commencement.
- Delay of >30 mins between presentation and triage.
- Inability to provide continuous 1:1 care and support in established labour.
- Missed or delayed care.

Appendix 2

Checklist for Opel 2/3/4 actions (print or make digital copy to annotate)

Description	**Opel 2** **The local maternity service is starting to show signs of pressure. The maternity service will be required to take focused actions to mitigate the need for further escalation.** **Enhanced coordination and communication will alert the whole system to take appropriate & timely actions to reduce the level of pressure in the system.**	
Triggers *(circle/ highlight as appropriate)*	• Enough beds for delivery suite/ Labour ward to transfer to wards but not for elective activity. • High activity with high bed occupancy but beds remain available on delivery suite. • Women not assessed within 15 minutes in orange category for triage. • Moving staff to be able to give 1-1 care in established labour. • Birth rate plus activity & dependency score rating AMBER for delivery suite. • Labour ward coordinator is temporarily not supernumerary (providing direct care to antenatal/postnatal women whilst extra support for delivery suite is provided. • Delays in elective activity for > 4 hours. • Neonatal service is experiencing difficulty in meeting anticipated demand with available resources (Neonatal services escalating through Neonatal OPEL framework). Management at this level remains at Duty Manager/ Labour Ward Coordinator/ BMW Ward Lead/ Maternity Matron/ Neonatal Matron (or deputy)/ Consultant Obstetrician.	
Actions required (in hours) *Tick in column when completed*		• 2 hourly ward rounds to ensure flow and discharge of antenatal & postnatal patients. • Labour ward coordinator. BMW ward lead and Duty manager to identify women suitable for discharge and expedite medical review where necessary Ensure all space is utilised, using waiting areas in Day Assessment Unit and postnatal area for women and babies ready for discharge • Any delays in discharges/prescribing of TTO's to be escalated to the Maternity Duty Manager. • Discussion between delivery suite coordinator/Duty manager of the day and consultant obstetrician to consider rescheduling all elective work both inductions and LSCS (Lower segment c-section) if clinical conditions permit • Discuss with Housekeeping services for extra cleaning staff to ensure bed and equipment is

		cleaned and increase through put and flow • Duty Manager and Labour Ward Coordinator to liaise and redeploy skilled staff according to area of need. Consider deployment specialist midwives, community midwives, whether study leave needs to be cancelled and identify if any staff can work extra/ longer shift to support safe care delivery. If Continuity of Carer model in place, should be maintained wherever possible. • Labour ward coordinator to liaise with Duty Manager and Neonatal Nurse in charge to identify and plan for any anticipated activity that necessitates neonatal cots, this may require Consultant Paediatrician and Consultant Obstetrician to discuss. • Early identification and planning where possible to ensure that women whose babies may not be accommodated on the neonatal. • Unit are transferred to other units in the daytime when staffing levels are optimal. • Request additional bank and agency staff including midwives, maternity support workers and health care workers via the Duty Manager, who will then in turn escalate via daily staffing calls. • All staff to be kept briefed of situation and actions agreed (maternity handover/safety huddles). Consider and plan additional safety huddles as required. OPEL status should be shared with the staffing and capacity team via the daily calls. Out of hours the Site team (Bleep 1312) should be informed of OPEL status.
Actions required (out of hours) *Tick in column when completed*		Labour Ward Coordinator, Duty Manager and Consultant Obstetrician on call assess the situation and create a plan to improve the situation and call Tier 2 on call as required. They will liaise with the Trust Duty Manager to provide extra cleaning and maximise available support to manage bed clearance • Alert paediatrician on call. • If problems encountered with transporting home or to other hospitals, or women blocking beds either awaiting investigation or interim report, hospital site team to assist.
Frequency of review *Tick in column*		Labour ward coordinator and Duty Manager to identify women suitable for discharge and expedite medical review where necessary or duty manager should: • Review OPEL Maternity Framework (MF) status which includes staffing, skill mix and bed capacity 4 hourly. The OPEL status is shared once per shift at the safety huddle and at Trust staffing and capacity meetings.

when completed		• Take steps to remedy staffing levels acuity, if necessary, by redeploying staff around the service in line with activity and identify women suitable for discharge.

Description	**Opel 3** **The local maternity service is experiencing major pressures compromising patient flow and safety and continues to increase Further urgent actions are now required across the whole Local Maternity & Neonatal System and increased external support may be required.** **Regional Teams will be made aware of rising system pressure, providing additional support as deemed appropriate.**	
Triggers *(circle/ highlight as appropriate)*	• Not enough beds on Beatrice Maternity Ward (BMW) for delivery suite/ Labour ward to transfer or elective activity. • Upper limits of bed capacity on delivery suite/ Labour ward, no potential bed capacity within 2 hours. • Women not seen in red category immediately for triage. • Unable to give 1-1 care to woman/birthing person in established labour. • Birth rate plus activity & dependency score rating RED for delivery suite. • Labour ward coordinator not supernumerary. • Delays in elective activity for >24hours. • Neonatal services - very limited ability to maintain patient flow in line with ODN pathways.	
Actions required (in hours) *Tick in column when completed*		• Ensure OPEL MF 2 actions are completed. • Duty manager update on the thrice daily sit capacity calls and inform the Divisional Director of Operations (DDO) • Staffing concerns or capacity issues raised. Inform divisional leadership team and active involvement of the Director/Head of midwifery/designated lead in absence of Dom/HoM • OPEL MF 3 communication across the LMNS to alert organisation to pressure points this must also include board maternity safety champions and non-executive safety champions • Escalation with executive level involvement and coordinated response across the ICS/LMNS (Local Maternity Neonatal System). Inform neighbouring units and obtain their status to see how they can support future diversions this will likely involve both SHIP and BSW LMNSs.

		• New Request for additional bank staff including midwives, nurses, maternity support workers and health care workers • Liaise with medical wards to request support for care of any women < 20 weeks gestation Trust arrangements • Consider additional nursing staff to recover women post caesarean section or following operative procedure • Consider using prescribing pharmacist or competent nurses to complete drug rounds on wards • Consider the option of the community midwife undertaking newborn and infant physical examination (NIPE) in the mother's own home to support rapid early discharge of mothers and babies • Reducing and postponing community midwifery visits. For antenatal visits if a woman/birthing person requires the need for a physical examination and/or screening these visits should be maintained (A/N visits to postpone for low-risk women 16, 25, 31week appointments). Consider for postnatal visits to consider provision of care by Band 5 midwives, senior student midwives and maternity support workers. Postpone in person visits particularly for healthy term multiparous women and their babies • Divisional Director of Operations and Director of Midwifery to consider the potential for additional governance, data, and administrative support for maternity services, as all midwives working in those teams will be moved to support front line delivery of clinical services • Creation, where possible, of extra high-risk labour beds – need to ensure safe staffing and availability of extra medical staff and obstetric theatre teams • Local services to consider contingency plans to maintain homebirth services • Utilisation of other staff groups including neonatal and paediatric nurses to care for transitional care babies • Continue to engage the neonatal ODNs in surge planning to ensure access to neonatal critical care is maintained and not compromised • Ensure regular and formal contact with Maternity and Neonatal Voice Partnerships (MNVP), to ensure consistent communication to service users. MNVPs to share and amplify key messages to women, their families and members of the public using established communication routes

		• Trust communications department to support comms across the organisation and into the community. • If all OPEL MF Status 2 actions and all the additional OPEL MF 3 actions above have been completed and the unit is still unsafe, initiate a temporary diversion for all admissions, following discussion with the on- call consultant obstetrician, Duty manager, director, or head of midwifery with agreement from the Divisional Director of Operations and the Trust duty manager and the Executive on call. • Work collaboratively with ambulance Trusts to ensure routine escalation policies are enacted when required. Inform SWAST/SCAS of Opel 3 status. Staffing/capacity issues not resolved commence a divert in accordance with NHS England/Improvement Standard Operating Procedure and Reporting Process: Requesting Ambulance Diverts: https://www.england.nhs.uk/publication/operational-pressuresescalation-levels-framework/ • Report any immediate risks to the site team for escalation if appropriate • Duty Manager, Labour Ward Coordinator, Consultant Obstetrician, Consultant Paediatrician, Consultant Anaesthetist, maternity matrons to maintain communication until stand down from OPEL MF 3
Actions required (out of hours) *Tick in column when completed*		Labour ward coordinator/ Duty Manager/Tier 2 Senior midwifery manager on call and consultant obstetrician on call assess the situation and create a plan to improve the situation. • Maternity Duty manager to remain onsite whilst OPEL MF 3 status continues. • Maternity Duty Manager to inform the clinical site team and Trust Duty Manager via switchboard. • Labour ward coordinator/ Duty Manager/Tier 2 Senior midwifery manager on call and consultant obstetrician on call to maintain communication until stand down from OPEL MF 3 status
Frequency of review *Tick in column when completed*		Labour ward coordinator and Duty manager on call to identify women suitable for discharge and expedite medical review where necessary and Duty manager/matron of the day should: • Review OPEL MF Status staffing, skill mix and bed capacity 2 hourly. • Bed capacity hourly review should be managed by the Duty manager in hours and out of hours by Duty manager on call with the Labour ward Coordinator. • Take steps to remedy staffing levels acuity, if necessary, by redeploying staff around the service in line with activity and identify women suitable for discharge.

Description	**Opel 4** **Pressure in the local maternity service continues to escalate leaving organisations unable to deliver comprehensive care which has the potential for patient safety to be compromised Decisive action must be taken locally to recover capacity and ensure patient safety** **All available local escalations actions have been taken, external extensive support and intervention is required.**
Triggers (*circle/highlight as appropriate*)	• No beds on wards. • No beds on delivery suite/ Labour Ward. • No beds for triage. • Not able to give 1-1 care in established labour. • Birth rate plus activity & dependency score rating RED for delivery suite. • Labour ward coordinators not supernumerary. • Unable to transfer to another Trust for elective activity. • Neonatal services – demand exceeds available resource (refer to Neonatal Escalation Policy). • Prioritisation on a case-by-case basis is required.
Actions required (in hours) *Tick in column when completed*	• Ensure OPEL 2 & OPEL 3 actions are completed. • Director of Midwifery and Neonatal Services to inform Trust Executive on call that divert, and closure is to be implemented. Trust Duty Manager to inform Executive on-call. • Complete checklist for suspension (Opel 4) of Maternity services (Appendix 3). • Staffing/capacity issues not resolved commence a divert in accordance with NHS England/Improvement Standard Operating Procedure and Reporting Process: Requesting Ambulance Diverts: https://www.england.nhs.uk/publication/operational-pressures-escalation-levels-framework/ • Responsible person for ICS to be notified in line with contractual arrangements and actions outlined. • Suspend all admissions to maternity unit. • Suspend all community births. • In-utero transfer to a centre with a NICU is the optimal approach where preterm labour <27/40 is anticipated. All babies <27/40 (whether in - or ex-utero) must be referred for transfer to a hospital with a Level 3 NICU, if clinically appropriate. The receiving hospital should accept the referral, whenever possible, and there must be consultant to consultant discussion, which will

		include the obstetric consultant in the case of an in-utero transfer, to resolve any issues in relation to transfer. • In the event of extreme workforce/ capacity issues, it is recognised that the availability of ambulance and midwifery staff will have significant impact on the ability to achieve this and cases will have to be decided on a case-by-case basis. This should be managed through the Maternity Duty Manager, Labour Ward Coordinator, and Consultant Obstetrician on-call. • A contingency plan must be put in place for women that may unexpectedly attend Labour ward & triage areas without notice, to manage care safely. • Submit Datix confirming OPEL 4 status. • If there are multiple sites requiring OPEL MF 4 actions and mutual aid is being sought but is not forthcoming due to high and sustained pressures across multiple systems, which means that maternity units cannot decompress impacting on the safety of mothers and babies, the regional team to be contacted and request for out of locality / region assistance to ensure a collaborative coordinated response to escalation including mutual aid where appropriate. Maternity Duty Manager, Labour Ward Coordinator, Consultant Obstetrician, Consultant Neonatologist, Director of Maternity & Neonatal Services, Clinical Director and Divisional Director of Operations and Executive on call to maintain communication until stand down from OPEL MF 4 status.

Appendix 3

Checklist for suspension (Opel 4) of Maternity Services

Date of Decision:		
Time of Decision:		
Reason for suspension: **(Please see detail daily SITREP)**		
Checklist completed by:	**Name**	**Date/Time/Informed**
Duty Manager		
Consultant Obstetrician on Call		
Consultant anaesthetist on call		
HOM / DOM		
Clinical Director		
SFT Tier 2 Site and Trust DM		
SFT Tier 3 Exec on call		
Hospitals contacted (See Appendix 3)		
RUH & GWH		

SWAST		
Neonatal Unit		
Emergency Department		
Datix Report Complete		

Appendix 4

Details of hospitals to contact:

Hospitals contacted:

Date completed:

Referral Hospitals **Patient details recorded on Appendix 5**	Time	Name of contact	Can accept? Y/N	Details / Process
WINCHESTER Royal Hampshire County Hospital Romsey Road Winchester SO22 5DG Tel: 01962 863535				
SOUTHAMPTON Princess Anne Hospital Coxford Road Shirley Southampton SO16 5YA Tel: 02380 777222				
BASINGSTOKE Basingstoke and North Hampshire Hospital Aldermaston Road Basginstoke RG249NA Tel: 01256 473202				

POOLE Poole Hospital Longfleet Road Poole BH15 2JB Tel: 01202 665511				
BATH Royal United Hospital Combe Park Bath BA1 3NG Tel: 01225 428331				
SWINDON Great Western Hospital Marlborough Road Swindon SN3 6BB Tel: 01793 604020				

Appendix 5

Checklist to reopen maternity services

Date of Decision:					
Time of Decision:					
Reason for suspension: **(Please see detail daily SITREP)**					
Checklist completed by:				**Name**	**Date/Time/Informed**
Duty Manager					
Consultant Obstetrician on Call					
Consultant Anaesthetist on call					
HOM / DOM					
Clinical Director					
SFT Tier 2 Site and Trust DM					
SFT Tier 3 Exec on call					
Hospital Contacted (Appendix 3)				**Contact Name/Tel No**	**Date/Time**
Hospital	**Accept**	**Yes**	**No**		
Winchester	**Accept**	**Yes**	**No**		
Southampton	**Accept**	**Yes**	**No**		
Basingstoke	**Accept**	**Yes**	**No**		

Poole	**Accept**	**Yes**	**No**		
Bath	**Accept**	**Yes**	**No**		
Swindon	**Accept**	**Yes**	**No**		
RUH & GWH					
SWAST					
Neonatal Unit					
Emergency Department					
Datix Report Complete					